BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

MICHAEL VARGAS	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,012,667
DAN MORRIS PAPER HANGING, INC.	)	
Respondent	)	
AND	)	
	)	
BUILDERS' ASSOCIATION SELF-INSURERS' FUND	)	
Insurance Carrier	)	

ORDER

Claimant appeals the April 28, 2005 Award of Administrative Law Judge Kenneth J. Hursh. Claimant was awarded benefits for a 10 percent impairment to the body as a whole on a functional basis with his award limited to a functional impairment as claimant was earning at least 90 percent of his average weekly wage at the time of the Award. Therefore, pursuant to K.S.A. 44-510e, claimant's award is limited to his functional impairment. The ALJ also denied reimbursement of certain medical expenses associated with the treatment of claimant's work-related injuries. Oral argument was held before the Appeals Board on August 24, 2005.

APPEARANCES

Claimant appeared by his attorney, John R. Stanley of Overland Park, Kansas. Respondent and its insurance carrier appeared by their attorney, Wade A. Dorothy of Lenexa, Kansas.

RECORD AND STIPULATIONS

The Appeals Board (Board) has considered the record and adopts the stipulations contained in the Award of the Administrative Law Judge (ALJ).

ISSUES

1. What is the nature and extent of claimant's injury? (The parties acknowledge that as claimant is earning 90 percent or more of his

average weekly wage, claimant's award is limited to his functional impairment only pursuant to K.S.A. 44-510e.)

2. Is claimant and/or claimant's health insurance carrier entitled to reimbursement of medical expenses associated with the care and treatment stemming from the injury of April 4, 2003?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the entire evidentiary file contained herein, the Board finds as follows:

Claimant was working as a painter for respondent when, on April 4, 2003, he felt a pinch in his back while picking up some paint cans. Claimant did not consider it to be significant, but a few minutes later, while climbing a ladder and turning, claimant felt a sharp pain in his low back with radiculopathy down into his right leg. A co-worker, Bruce Porretti, was working with claimant at the time of the incident. Mr. Porretti stated that claimant turned to talk to Mr. Porretti, said a couple of cuss words, grabbed his right hip and started going down. Claimant told Mr. Porretti at that time that he had injured his back. Mr. Porretti testified that claimant told him he thought it was a muscle spasm, but he (claimant) did not know. However, claimant's testimony was that he never said he was having a muscle spasm. Claimant could not straighten up. Claimant was lying on the floor, holding his leg, when Charles Daniel Morris, the sole owner of the respondent company, came in. Mr. Morris observed claimant lying on the floor, holding his leg. Mr. Morris described claimant as being in the fetal position, holding his right thigh. Mr. Morris testified that claimant told him he was having a muscle spasm,[1] which Mr. Morris immediately assumed was from an injury suffered by claimant in January[2] 2003, when he slipped and fell on ice. Mr. Morris determined that because claimant was not showing pain on his face to a significant degree, that he was not in "too much pain," even though claimant was lying on the floor at the time. Mr. Morris testified that claimant was able to get up off the floor and move around. Claimant tried to work, but was unable to continue working through the day, and Mr. Porretti called claimant's wife. Claimant's wife appeared around 2:00 in the afternoon, taking claimant to the emergency room.

Claimant underwent several tests including an MRI scan which showed significant degenerative disc disease at L4-5 and L5-S1, with disc herniation at L4-5. Claimant's

---

[1] Claimant's testimony was that Mr. Morris told claimant he was having a muscle spasm and told claimant to go lie down and try to stretch it out. In addition, claimant testified that he (claimant) did not believe he was just having a muscle spasm. (See Cont. of R.H. Trans. (Nov. 16, 2004) at 16 and 48; see also Cont. of R.H. Trans. (Dec. 7, 2004) at 14.)

[2] Mr. Morris testified that the injury where claimant slipped and fell on ice occurred in February 2003. (See Morris Depo. (Oct. 12, 2004) at 22 and 61.)

history is significant in that in 1997, he underwent a percutaneous microdiskectomy at L4-5 and had experienced occasional back pains since that time.

Claimant was referred to Vito J. Carabetta, M.D., board certified in physical medicine. Dr. Carabetta examined claimant on November 7, 2003, pursuant to an Order by the ALJ. Dr. Carabetta diagnosed claimant with status post lumbar surgery for a recurrent L4-5 disc herniation, which was the same level as his prior surgery. He rated claimant at 10 percent to the body as a whole based upon the fourth edition of the AMA *Guides*,[3] DRE Category III.

Claimant was also examined on February 20, 2004, by P. Brent Koprivica, M.D., board certified in emergency medicine, on a referral from claimant's attorney. Dr. Koprivica reviewed the MRI scan from April 8, 2003, diagnosing claimant with degenerative disc disease at L4-5 and L5-S1, with a significant disc herniation at L4-5. He also found claimant to have suffered a 20 percent impairment to the body as a whole based upon the fourth edition of the AMA *Guides*.[4] Dr. Koprivica, however, used the range of motion model rather than the DRE model, finding, in this instance, he did not believe the DRE model was sufficiently representative of the surgery and injury claimant suffered. He acknowledged that if he used DRE category method, claimant would fall within Category III of the DRE for a 10 percent impairment to the body as a whole.

At the time of the injury, claimant proceeded to the emergency room and was later referred to the Headache and Pain Center, where he underwent x-rays, epidural injections and an MRI. He ultimately underwent surgery at the L5-S1 level. This is a different level from the surgery claimant had in 1997. Claimant acknowledges the bills were paid by his health insurance and out of pocket, with the total medical bills reaching nearly $32,000.

Claimant testified that he did not pursue a workers compensation claim in this instance because he had observed his co-worker, Mr. Porretti, make a claim against the owner, Mr. Morris, for a workers compensation claim. Claimant testified that Mr. Porretti was treated poorly by Mr. Morris. Claimant testified at the regular hearing that Mr. Morris had contacted claimant and requested that he lie about how Mr. Porretti had injured his back. Claimant testified that rather than go through the hassle, since he needed immediate medical attention, he decided to get the medical attention on his own.

Mr. Morris, who observed claimant lying the floor, grabbing his leg and complaining of back problems, did not offer any type of medical care. In fact, Mr. Morris made the instant determination that claimant's injury was associated with a fall that occurred in January of that year, several months prior, even though claimant had continued working

---

[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

[4] AMA *Guides* (4th ed.).

after that fall with no apparent limitations. Mr. Morris testified that claimant may have missed a couple of days work after the earlier fall, but after returning to work, claimant provided no restrictions of any kind. Mr. Morris was asked if he had any information to support his contention that claimant's need for surgery was due to the earlier slip and fall on the ice. Mr. Morris testified he had no evidence to support that belief. Mr. Morris testified that Mr. Porretti advised him that claimant said that the surgery was as a result of the slip and fall in January. However, Mr. Porretti denied telling Mr. Morris that claimant told him that he injured his back when he slipped on the ice.

Mr. Porretti testified when he suffered an earlier work-related injury, he was contacted by the insurance company and advised that Mr. Morris was "going to fight it." Mr. Morris apparently claimed that Mr. Porretti had injured his back at his mother's house. Mr. Porretti denied this. Additionally, as noted above, claimant testified that Mr. Morris had requested that he lie and say that Mr. Porretti had injured his back at his mother's house. Claimant refused.

In workers compensation litigation, it is the claimant's burden to prove his entitlement to benefits by a preponderance of the credible evidence.[5]

> Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.[6]

The record contains two opinions regarding claimant's functional impairment. Dr. Koprivica assessed claimant a 20 percent impairment utilizing the fourth edition of the AMA *Guides*,[7] but rather than using the DRE section, Dr. Koprivica used the range of motion model. Except under certain specific circumstances, the AMA *Guides* recommend the DRE as the preferred method when evaluating low back injuries. Dr. Koprivica acknowledged that under the DRE, a 10 percent impairment would be appropriate, even though he felt the DRE was inadequate in this instance.

Dr. Carabetta, on the other hand, found the DRE method to be appropriate, assessing claimant a 10 percent impairment utilizing same. The Board finds, as did the ALJ, that the DRE method, which is preferred under the *Guides*, equates to a 10 percent impairment to claimant's low back. The ALJ awarded claimant a 10 percent impairment, and the Board affirms same.

---

[5] K.S.A. 44-501 and K.S.A. 2002 Supp. 44-508(g).

[6] K.S.A. 44-510e(a).

[7] AMA *Guides* (4th ed.).

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation . . . . as may be reasonably necessary to cure and relieve the employee from the effects of the injury.[8]

In this instance, claimant suffered an injury on the job, which was observed by a co-worker. Claimant was also observed by the owner-employer within minutes of falling to the ground with back spasms. The owner made the instant determination that claimant's injury was a result of a non-work-related incident which occurred several months earlier for which claimant had received no restrictions and from which claimant had returned to work, performing his regular duties. Claimant's decision to pursue treatment through his health care provider was partially based upon his observation of the owner's past practice when dealing with workers compensation claims, namely that of Mr. Porretti.

The Board finds this respondent to be in violation of the policy set forth in K.S.A. 2002 Supp. 44-510h. Apparently, respondent-owner had a history of denying workers compensation claims, going so far as to encourage false testimony or attempting to falsify the record regarding the cause of alleged injuries. Mr. Morris's actions when Mr. Porretti filed a claim, as well as his actions and determinations when he observed claimant lying on the floor, speak volumes. An employer cannot avoid its obligation to provide workers compensation care for work-related injuries simply by denying without justification the cause of that injury. The Board finds this respondent, being in violation of K.S.A. 2002 Supp. 44-510h, is obligated to provide the medical care to cure and relieve claimant of the effects of the injury. The Board, therefore, finds that claimant is entitled to reimbursement for the monies expended for the care and treatment of his low back stemming from the injury of April 4, 2003. The Board acknowledges that the funds paid by claimant or through a private health insurance carrier may not be identical to the funds allowed under the Workers Compensation Act. Therefore, any reimbursement payable from respondent shall be subject to the medical fee schedule created under K.S.A. 2002 Supp. 44-510i. Any dispute associated with the services rendered and the costs associated with that service may be resolved through the utilization and peer review process set forth in K.S.A. 44-510j.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Award of Administrative Law Judge Kenneth J. Hursh dated April 28, 2005, should be, and is hereby, affirmed with regard to claimant's 10 percent impairment to the body as a whole, but reversed with regard to denying claimant's entitlement to reimbursement for the

[8] K.S.A. 2002 Supp. 44-510h(a).

medical costs associated with the care and treatment of his April 4, 2003 work-related injury.

In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

IT IS SO ORDERED.

Dated this ____ day of October, 2005.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: John R. Stanley, Attorney for Claimant
Wade A. Dorothy, Attorney for Respondent and its Insurance Carrier
Kenneth J. Hursh, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director